SPECIAL SERIES—PART III

The Quest for Mercy
The Forgotten Ingredient in Health Care Reform

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Section III—The Broadening Scope of Health Care

Chapter 7

Treating Individuals While Tending to Populations

Our nation's health care system is being soundly criticized for costing too much and serving too few. Millions of people go without basic medical care because they cannot afford it. Miraculous operations (such as organ transplants) take place, but epidemics of preventable childhood diseases (such as measles) wipe out scores of unimmunized children. This situation illustrates a fundamental tension between American society's emphasis on individualism and our sense of responsibility for community welfare—derived from the American Constitution's mandate to "promote the general welfare." Since these words were written in the eighteenth century, however, it has become far more complicated to take on this responsibility.

Many see the challenges facing today's health care system as a symbol of the rift between two professions that play major roles in maintaining health: medicine and public health. Claims that the health care "crisis" can be solved only through the union of medicine and public health are being figured into reform proposals, school curricula, and plans for allocating federal research dollars. There are calls for primary care doctors to practice in community health centers; for physicians and other health care professionals to counsel their patients about the link between behavior and disease; for medical interventions to be evaluated in terms of both patient outcomes and their impact on the burden of disease on the population; and for epidemiologic research to yield clues about preventable environmental risk factors and threats to health.

That public health and medicine should be partners in promoting and maintaining health seems eminently logical. So, insofar as we have not yet achieved the proper balance, where did we go wrong? The story begins with the birth of public health as a distinct endeavor.

Public Health's Beginnings

Throughout history, epidemics of such diseases as plague, cholera, and smallpox have evoked public efforts to protect the health of citizens through the isolation of ill persons and quarantine of travelers. Such efforts occurred even though epidemic disease was often believed to be a sign of poor moral and spiritual conditions.

At the turn of the nineteenth century, what was known as "the great sanitary awakening" identified filth as both a cause of disease and a vehicle of transmission. Momentous discoveries in the latter half of the century by such scientists as the German physician and bacteriologist Robert Koch, whose now famous "postulates" revealed the link between microorganisms and certain diseases, transformed the way in which epidemics were understood and combated. To this day, Koch's postulates provide a framework for the study of the etiology of any infectious disease.

The sanitary awakening, coupled with the birth and flourishing of medical microbiology, spurred an embrace of cleanliness and a dramatic shift in the way

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society thought about health: Illness came to be seen more as an indicator of poor social and environmental conditions and less as evidence of poor moral and spiritual conditions. These events also changed the way society viewed public responsibility for communal health. As historian Elizabeth Fee notes, "Poverty and disease could no longer be treated simply as individual failings." Public sewage drainage, waste disposal, and water purification systems were put into place, as were the voluntary hospitals that were a significant sign of community responsibility for citizen health.

As a result of nineteenth-century developments, pasteurization and immunication emerged as strategies for controlling and even preventing some diseases, such as tuberculosis and smallpox. The growing knowledge about sources of and strategies for controlling infectious diseases, and public acceptance of disease control as both feasible and obligatory, shaped the development of the field of public health.

Professional Turfs

Initially, medicine and public health were allies in efforts to maintain the health of communities. The two fields shared in their investment in epidemiology (the study of disease in populations), and practicing clinicians, in large part, made up the membership of professional epidemiologic societies. Ironically, the paths of medicine and public health began to diverge just as advances in bacteriology produced increasing evidence that the paths should merge. Not surprisingly, in the United States, tension over professional "turf" was at the heart of the matter.

Causes of Disease

The turning point in the history of the relationship between the public health establishment and the practicing clinical community came early in the twentieth century, when public health practitioners entered into direct competition with practicing physicians by offering immunizations. In *The Social Transformation of American Medicine*, medical sociologist Paul Starr relates a story about early-twentieth-century tuberculosis control that illustrates a related point. He describes how requiring private doctors to give notification of tuberculosis to public health departments increased the tensions between medicine and public health:

> There was ordinarily no interference with patients under the care of private practitioners, and other consumptives were generally only visited by medical inspectors, who left circulars and gave advice about preventing the spread of infection. But fear of tuberculosis was widespread, and many people were anxious about any official report of its presence in their family; some life insurance policies were void if tuberculosis was the cause of death. Objecting that tuberculosis was not contagious, practitioners opposed compulsory reporting as an invasion of their relationships with patients and of patients' rights to confidentiality. The president of the New York County Medical Society told its membership in 1897 that by requiring notification and offering free treatment, the health department was "usurping the duties, rights, and privileges of the medical profession."

Public Health Evaluations of Clinicians

Another sort of tension that has separated clinicians and public health professionals is the growing tendency of the latter to function as assessors, evaluators, and critics of medical practice. An early example of this tension is the tragic story of Ignaz Semmelweis, the great nineteenth-century Hungarian obstetrician who discovered how to protect women from dying of puerperal sepsis after childbirth. Semmelweis observed different mortality rates between a clinic staffed by midwives and another staffed by doctors and medical students. He noticed that in the one staffed by doctors and students, clinicians were failing to wash their hands between pelvic examinations, and deduced that they were thus carrying infection from patient to patient and from autopsy to patient. Semmelweis further recognized the similarity at autopsy between death of puerperal sepsis and death of wound infection, and he emphasized the efficacy of handwashing with lime before attending deliveries. Finally, he demonstrated an extraordinary difference in maternal death rates in his own practice; his were much lower than those of his colleagues.

At that time, however, the medical community was unwilling to accept the link between handwashing and infection. For his outspoken advocacy against standard practice, Semmelweis was derided and effectively forced out of the profession. Broken in spirit, he died in an asylum, as young women continued to die by the thousands due to the inflexibility and closed-mindedness of well-intentioned, yet entrenched, practitioners.

The increasing role in medical care of what are now called the "clinical evaluative sciences" exemplifies the tension between clinicians and public health professionals today. The term refers to the application of epidemiology, sociology, anthropology, and statistics to the assessment of health care. As such, this research is often thought of as a public health–based enterprise. By its very nature, it is an activity outside the apparatus for the delivery of services. In many instances, what emerges from the clinical evaluative sciences is a tension between the active agent (the clinician) and the critic (the evaluative scientist or public health practitioner), with the latter telling the world about the inadequacies of the former. The tension is intensified when the clinician is someone who perceives him- or herself to be in the higher echelons of technical accomplishment within a specialty. Such a specialist may tend to criticize epidemiologic studies because the studies address the average level of competence—the collective success—and undervalue what the extraordinary surgeon or practitioner can achieve.

Politics

Political events also keep medicine and public health at odds. The relationship between medicine and public health soured further, for example, shortly after World War I, when public health workers tended to support national health insurance. Post–World War II federal initiatives in health care for the poor and elderly exacerbated already sensitive relations.

Organizational arrangements in education and service functions solidified the rift. The population-based sciences—epidemiology, demography, anthropology, sociology, economics, and health statistics—were relegated to the schools of public health, which were separated both geographically and ideologically from medical schools. State and regional public health departments were established separate from the personal health care system. Although relations between medicine and public health have improved in the past decade, suspicion, tension, and isolation persist in many sectors today.

Philosophical Differences

Paul Starr's account of tuberculosis-control efforts illustrates the friction between medicine and public health over professional turf. It also touches on something that has emerged as perhaps the most dominant force behind the separation of the two fields: the fundamentally different scientific paradigms under which they conceptualize and implement their activities.

Most physicians and medical school faculties operate under the Newtonian, reductionist, biomedical model, which emphasizes the understanding of disease and therapeutics at the molecular level. They tend to focus on individual patients, individual diseases, and the molecular interventions that will bring about particular effects.

Public health practitioners, on the other hand, work with a variety of academic disciplines, the most important of which being epidemiology. Such professionals study populations, demographic trends, and overall morbidity and mortality statistics.

Thus, medicine focuses on disease and its treatment; public health focuses on prevention. Medicine strives to understand the diseases that cause poor health; public health seeks strategies to promote good health. Medicine aims to improve the health of individuals through specific therapeutic interventions; public health aims to improve the conditions of life for everyone in the community.

The struggle between the two fields boils down to a patient-centered approach versus a population-based approach. Seminal questions that involve both approaches are increasingly being raised by clinicians, third-party payers, and policymakers alike. One question may be, "Because individual patients are members of populations, couldn't their treatment be undertaken (to their benefit) in the context of what is known about the population to which they belong?" Most people would agree that the answer is yes. The growing number of medical conditions that we understand as having their origins in environmental, behavioral, and sociological factors make this strategy increasingly undeniable.

In the past fifty years, declining mortality rates from infectious diseases have been replaced by rising mortality rates from cancer, injuries, and chronic diseases of the cardiovascular system. The agent responsible for death or disability has shifted increasingly from the microorganism to the person. The most critical health risks facing populations are no longer contaminated water supplies and insects, but automobiles, drugs, industrial pollution, and diets laden with fat, calories, and salt. Awareness of these new morbidity factors makes obvious the need for teamwork between the fields of public health and medicine.

Kerr White, one of the most important and articulate advocates of the remarriage of medicine and public health, and medical professor Julia Connelly note that for most of the twentieth century, medical schools have had two predominant approaches: laboratory based and clinical. The laboratory-based approach is concerned with cellular and molecular disease processes; the clinical approach focuses on the care of one patient at a time. Although the value of what has been achieved in biomedical research laboratories has been tremendous—from early medical miracles such as antibiotics to more recent breakthroughs in organ transplantation—there has emerged a serious overemphasis on curative interventions rather than preventive preactices. The overreaching curative gestalt of modern medicine has become associated with specialization, superspecialization, and an explosion of interventions and technologies to the exclusion, many argue, of other equally important considerations bearing on the patient's care and well-being. In the intense concentration on research and technology designed to unravel disease mechanisms in individuals, many people believe medicine has become overly disease oriented and has lost touch with the people suffering from disease.

In an essay on the role of physicians in health promotion, physician Robert Lawrence points out the tendency for some of the awe-inspiring technologies of modern medicine to overshadow many of the public health enterprise's intervention strategies, which are frequently less dramatic or glamorous. He writes:

> In health promotion, we encounter issues of personal behavior, culture, values, and law. The triumphs of modern medicine are the results of experimentation and reductionism, of systematic attempts to remove all considerations of personal behavior, culture, and the like, to understand biologic systems.

Moreover, adds Lawrence, the more immediate feedback provided by successful treatment of symptomatic disease reinforces the physician's interest in pathology and therapeutics rather than in prevention or health promotion.

Health promotion and disease prevention present no "problem" for physicians; the emphasis is on health, on nonevents. Richard Pels and colleagues point out that

health promotion involves "no dramatic surgical intervention, and the grateful patient is replaced by someone unlikely to credit, much less praise, the physician for improving the probability of a longer and better life." Moreover, the nature and scope of epidemiologic research, by its, can make its returns slow, although the returns can be particularly powerful.

Medical Education

Clues abound as to why the training of physicians has exacerbated the rift between medicine and public health. Most aspiring medical students load their premedical curriculum with the biological and chemical sciences, a pattern that continues into at least the first two years of medical school. Medical curricula lack sufficient formal exploration of the society in which students will diagnose and treat people when they graduate. From the student's point of view, a lack of knowledge in the so-called "hard" sciences (relating to curative medicine) can end up actually hurting patients; a lack of knowledge in the social sciences, however, would seem to have little immediate negative impact. Psychiatrist and medical educator Leon Eisenberg offers a possible explanation for the short shrift given to the social sciences:

> There is widespread skepticism among physicians as to whether psychological and social factors are as "real" as biological ones. Classroom exercises will have convinced all of them of the power of biological reductionism. It is not only that so much more time is devoted to the natural as opposed to the "unnatural" sciences in medical education, but that the elegance of molecular biology is so much greater.

The infrastructure of medical education may also be a barrier to the study of communities. Much of medical education takes place at the bedside of sick individuals in tertiary care institutions, even though demographic and lifestyle shifts have greatly reduced society's need for tertiary care. Historically, outpatient service, the hospital's greatest link to the community, has been viewed as an "appendage" and a "charitable impulse," not as a site for medical education. Although positive steps have been taken to reshape admissions criteria, encourage the blossoming of community-based preceptorships, and create departments of community medicine, long-ingrained patterns are resistant to change.

Today, as always, physicians are trained to be problem solvers and to focus on the physical symptoms of the individual patient. Physicians are typically not trained to think in terms of prevention, health promotion, or social or psychological influences on health. In the words of one observer, physicians work in a "sickness industry"; this may explain, he adds, why they have been known to ignore things like child abuse, believing the issue to be none of their business. Although physicians frequently provide secondary or tertiary prevention services (for example, administering cholesterol-lowering drugs to prevent cardiovascular problems), the notion of primary prevention—that is, altering risk factors before they have even begun to influence human physiology in preclinical states—is something that most physicians still relegate to the domain of public health.

It is noteworthy that several studies report that physicians lack confidence in their ability to motivate behavioral changes in their patients, and they believe themselves poorly trained to practice preventive medicine. Lack of confidence typically correlates with little or no effort to counsel patients and with early cessation of counseling when working with less-motivated patients. Confidence levels tend to increase with the level of training. Surveys also document that physicians frequently do not adhere to preventive-practice recommendations because they perceive the recommendations as ambiguous or conflicting.

The literature can be confounding—comparable to, for instance, trying to discern whether butter or margarine clogs arteries faster. Part of the frustration may lie with the poor coordination between health services and the evaluative sciences, which are still in large part sequestered in the domain of public health. Evaluative statistical studies are often inconclusive and ambiguous, especially when it comes to working out the odds for a particular patient considering a particular intervention. Physicians also may find it difficult to assimilate new findings into their practices because of the rapid pace at which biomedical research moves forward.

Constraints of the practice setting can also hamper a physician's prevention and health promotion activities. Time pressures in busy primary care practices can interfere with delivering prevention and health promotion services. In addition, many practices do not have easy access to dietitians, smoking-cessation groups, alcoholism counselors, and other referral services that can help implement and provide educational support for health promotion interventions.

Joining Forces in Academia

Given the huge number of preventable deaths that occur each year due to cancer, cardiovascular disease, and tobacco and alcohol use, the great challenge to physicians and their health care teammates is to devote more attention to helping patients adopt healthy behavior. Increasing numbers of injuries, sexually transmitted diseases, and chronic diseases loudly signal the need for health care professionals to emphasize disease prevention and health promotion. Public health and medicine need each other. The separate contributions of these fields to improving the nation's health have been profound. Together, through the coordination of each field's unique strengths, public health and medicine could achieve even more.

Reshaping medical school curricula is an important starting point in healing the fracture between medicine and public health. Population-based concepts and skills must be taught to medical students; physicians need knowledge of statistics and epidemiologic concepts if

they are to evaluate information effectively and efficiently. Equally important, knowledge of population-based approaches facilitates understanding of other vital elements that affect the natural history and management of illness. "Health of the Public," a medical education reform initiative of The Pew Charitable Trusts and the Rockefeller Foundation, outlines the need for instruction in diagnosis, treatment, and prevention to address not only the individual patient but also the community. It is within the community that the determinants of health and the factors influencing the severity of illness resulting from disease can be measured and modified. A number of forward-thinking medical schools have assimilated these considerations into their students' educational experience. More schools need to emulate this example.

Even if physicians working in managed care, health maintenance organizations, or other forms of organized delivery systems work largely on curing patients, they will need associates from nursing, public health, dentistry, and allied health to deliver preventive and health-promoting services. Thus, it is clear that the focus either on physicians or on public health professionals is too narrow to yield the best solutions. As we move to more organized and population-based systems of health care, we shall be looking to the health care team to deliver the requisite services. Our educational and curricular reform should include all major health professions, not simply medicine.

Medical students and students of other health care professions need to be taught to integrate more fully the principles of community-based comprehensive care. Public health curricula, likewise, must make a serious attempt to engage the principles of biology, biomedicine, and reductionist biomolecular interventions. These interventions are especially critical; the ongoing mapping of the human genome opens the prospect that a drop of blood at birth can yield genetic information that will predict the disease and illness patterns to be experienced (and perhaps prevented) throughout an individual's life. The same genetics, now taught extensively in medical schools, will soon make clear to future physicians they shall be armed more and more often with predictive risk information about currently healthy people so treatment can occur before sickness. Future physicians may be practicing preventive genetics! Thus, from a pedagogical point of view, more effective interprofessional teaching and learning should bring public health and medicine together. As students make choices between professional schools, they should include as a criterion the degree to which a school has been able to make this vital link.

It is clear that medicine must maintain the unique strengths of the medical approach. Nevertheless, the need for medical schools to be at the frontiers of innovation in technical and molecular medicine must not outweigh the need for the schools to shape their students and their services to meet the needs of the communities around them.

Similarly, schools of public health should maintain their unique strengths in epidemiology, health promotion, and disease prevention while, at the same time, seeking to understand better the basic principles and some of the more technical elements of biomedicine.

Balancing Curative and Preventive Care

Population-oriented public health professionals should also examine a phenomenon that I have labeled the "epidemiology of hope." I call it epidemiology because I believe it to be a population-based phenomenon; paradoxically, it also reaches the heart of the patient-centered medical model.

I refer to the fact that each American, no matter how healthy, has the benefit of knowing that throughout every state in the nation are major medical centers where the latest technologies and the most proficient specialists are available should serious illness or trauma occur. This population-based hope allows us all to believe that if something dreadful befalls us, we, too, might have a chance at dramatic interventions and a typically American new beginning.

With some form of national health insurance coverage around the corner and health care dollars tight, a shift toward a more population-based approach to health care offers a certain appeal. In Oregon, for example, efforts have even been made to rank health interventions according to their public health impact—that is, according to how much "bang for the buck" they provide a population.

Prevention and health promotion activities have been emphasized in recent national health care reform plans because most of the time the costs of these activities are reasonable and their benefits are real. Part of the mandate to public health and other health professions is to continue to research the efficiency, effectiveness, and value of health care interventions. The stimulus behind these evaluative efforts is positive: not only is it important to understand which prevention and therapeutic interventions work well, but it is also past time to curb the inflation in health care costs to which our high-tech approach has given impetus.

But something about this shift in orientation from a patient-focused medical approach to one that gives significant weight to communal needs (and communal finances) feels uncomfortable. It has become distressingly obvious that, to more effectively meet the needs of our population, the nation's health care system needs reform. Yet, we still have not been able to "jump in with both feet," discontinue coverage for medical technologies that help only a select few, and direct all of our scarce health care dollars toward health promotion and disease prevention. Our reluctance has little to do with our conviction that change is needed. It has much more to do, I believe, with the "epidemiology of hope."

The military recognizes the psychological value of this hope, expending millions of dollars on elaborate systems of transportation and graded health care installations to assure its fighting cadres that if they are

injured, everything will be done to save them. Interestingly, public health–oriented interventions have played upon this characteristically American, individualist hope for a second chance. Recall the slogan of a past campaign to encourage people to wear seat belts: "The life you save may be your own."

American people watch with interest and pride as medicine saves the lives of people who appear to be hopelessly ill, rescuing them from the brink of death. The most awesome medical miracles occur in hospitals, but with their steep costs, a growing consensus that we have too many hospital beds, and the movement of health care toward a more population-based, cost-conscious system, the need for so many high-tech and expensive institutions is being questioned. Here the epidemiology of hope arises, muddling the inquiry. Citizens may understand that their city has too many hospitals, but they still may be reluctant to close down the hospital nearest their home. What if they were in an automobile accident and needed trauma care? What if a loved one experienced a massive heart attack? Minutes could mean the difference between life and death.

Americans will not easily yield these institutions to the budgeteer's ax. In all likelihood, we will maintain a more rational sizing and distribution of our hospitals, which will increasingly become almost exclusively large intensive care units. In other words, they will be seen by the public, not incorrectly, as institutions dedicated to bringing people back from the brink of death.

I hope that we citizens will also economize and become much more prudent buyers of such care. We shall all continue to need good professional judgment to make balanced societal allocation decisions between curative and preventive care. To achieve this balance among our mature health providers, we need similar balance in our educational experiences. Although organized medicine and the public health establishment have frequently been at odds, respected professional leaders are working hard to remedy the situation; many are seeking training in both medicine and public health, and, more recently, experimenting with new kinds of educational venues and strategies. Although I believe the "official" gaps will disappear shortly, it will be up to the young people to integrate the two approaches so that each health care professional sees prevention and curing as components of a continuum rather than as irreconcilable competitors.

Chapter 8

Three Intellectual Paradigms for Both Education and Practice

These days, there are few more overused words than "paradigm." In 1952, a young professor named Thomas Kuhn gave an extended series of lectures in a natural science course I was taking as a college freshman. His lectures became the basis of his famous book, *The Structure of Scientific Revolutions*; he is the person who introduced the word paradigm to our modern thinking. Kuhn's point was that each scientific era or movement is governed by a theory, or paradigm. This revelation proved fruitful for those who accepted new paradigms and mined them for discoveries. Sometimes, however, when a new paradigm came onto the scene, it was resisted and resented by the establishment. The resulting struggle between paradigms would go on for decades before the new one would finally become dominant. It seems to me appropriate, and even important, to use the word paradigm to describe each of the three major theoretical prisms through which the twenty-first century healer must be able to view the world.

For the past fifty years, physicians have been armed with a growing supply of technical interventions resulting from the nation's investments in basic and applied medical science. This supply has become so pervasive, so effective much of the time, and so alluring both to patients and to practitioners that the profession may have fallen prey to the technologic imperative, losing sight of the healing effect of the physician and nurse as therapies in their own right.

Simply put, the clinician's functions fall into three categories: prevention, cure, and care. Prevention, which implies efforts to help motivate individual patients to adopt healthful lifestyles, also refers to the public health functions of populationwide initiatives. It includes a population-based approach rooted in the science of epidemiology, which I call "the Population-Based Public Health Paradigm."

Clearly, some physicians will act more directly than others in promoting health and preventing illness; only a few will dedicate their professional lives to public health. All physicians and other clinicians, however, need to support public health initiatives.

Reductionist Biomedical Paradigm

The modern cure mode, part of the Reductionist Biomedical Paradigm, rests on a disease-focused view, wherein practitioners attempt to understand the molecular defect causing a disease and to determine precise molecular curative interventions. Such molecular-level understanding is the building block for the best choice of treatments. The advances in both diagnosis and treatment over the past several decades stagger the imagination. The ongoing genetic revolution promises to yield products and techniques of unlimited promise in terms of both prevention and cure.

Many see this molecular-based, disease-focused paradigm, however, as minimizing the importance of the clinician's interpersonal skills in fostering trust, developing a therapeutic relationship, and factlitating a constructive use of the placebo effect. It underrates the importance of the clinician's ability to deal with patients afflicted by incurable diseases, suffering that accompanies chronic pain and illness, and the nature and quality of a patient's death and its ramifications for family and friends. The Reductionist Biomedical Paradigm does not address these issues.

Three Intellectual Paradigms for Health Care

	Population-Based Public Health	Reductionist Biomedical	Biophysical
Conceptual Basis	The health status of the population must be the subject of analysis if we are to measure and understand trends in our people's well-being.	This biomolecular paradigm rests upon the principles of modern reductionism and seeks to identify the molecular basis for disease states and molecular curative interventions.	There is a science to healing humans through human interaction and there are sciences that inform effective communication.
Core Academic Disciplines	Epidemiology Sociology Anthropology Political Science Demography Economics Organization and Management	Molecular biology Chemistry Physics Mathematics Physiology Microbiology Immunology Genetics	Psychology Communication Sciences Neuropsychiatry Sociology Anthropology Liberal Arts The Arts
Relative Importance to Prevention, Cure, and Care	Crucial importance to health promotion and disease prevention strategies and research priorities. Important in measuring impact of curative interventions.	Crucial importance to understanding disease and approaches for therapy, forming the bases for many specialties. Of growing importance in prevention (e.g., vaccines and mapping of genetic risks of disease).	Of most importance to the caring mode of medicine, especially in the treatment of chronic disorders, but perhaps having some significance to prevention and health promotion, especially in strategizing.
The Role of the Physician	To promote health and prevent disease by encouraging behavioral change (e.g., nutrition, exercise, vaccination) and attempting to alter risk factors (e.g., smoking, hypertension) before they cause disease. To promote an environment for healthful living. To work constructively on an inter-professional team deployed to deliver necessary and useful preventive and health promotional services.	To focus on the physiologic symptoms of the individual patient and to match treatment regimens with molecular basis of disease in accordance with the best scientific evidence in the context of the patient's situation and desires. To work with other relevant health professionals to ensure efficient delivery of curative services.	To use the interview not only as a tool for collecting objective information and measurements, but also for learning the nature and history of the patient's experiences and clarifying what they mean to the patient as an individual and as a member of society. The integrity of these personal interactions build trust on the part of the patient, enhance compliance with treatment regimens, and promote the placebo effect. To work with others to create a healing team and caring institutions.

Biopsychosocial Paradigm

The Biopsychosocial Paradigm, clearly espoused by George Engel, provides an intellectual construct that does address these matters. It identifies the disciplines that inform the strategies of human interaction necessary to serve most effectively as the basis for a therapeutic relationship and environment. Engel, Havens, Eisenberg, and Kleinman, among many others, have written extensively about the interface between culture and belief; the interpersonal strategies of the physician; the molecular disease afflicting the person's internal organs; and the process of healing the illness afflicting the whole person. This social science–based paradigm leads to the whole-person–oriented interactive skills so critical in helping people cope with illnesses that cannot be cured—skills that are particularly essential in the ongoing care of chronic afflictions.

Linking Two Paradigms With a Third

In recent years, I have sensed that there are growing cadres of young faculty across the spectrum of specialties who perceive medicine more broadly than the older faculty do. Students will probably find the majority of their professors still locked narrowly into one of the paradigms. For example, those faculty most concerned with population-based approaches to reducing the burden of illness on society will tend to scorn as feeble the contribution of much high-tech medicine to improving the societal health status.

Those who do not build bridges between paradigms may be ill-equipped to deliver the best care. For example, psychiatrists and other mental health professionals operating in the Biopsychosocial Paradigm who do not appreciate the benefits of biomedicine and public health risk isolating the mental health enterprise from the rest of the caregiving effort. Similarly, reductionists who fail to respect the theory behind mental health practice only magnify an unnecessary gulf separating "scientific" doctors from psychiatrists and psychologists. In building bridges to other paradigms, the molecularly oriented, technologically based physician should incorporate into the caregiving team people who possess skills from the realm of the Biopsychosocial Paradigm and vice versa.

The Population-Based Public Health Paradigm

One concept that might help both faculty and students bridge the gulf between paradigms is what I described earlier as the "epidemiology of hope"—that is, the hope that every American holds for revival or repair if disaster strikes. The epidemiology of hope is a societal benefit; many people, including myself, take pride in the amount of resources Americans commit to giving people another chance at life in situations where other societies might abandon them. Single-instance, expensive, reductionist, biomedical therapy that can be applied to only a few appropriate patients has a population-wide benefit: hope for all, should they become afflicted.

Family medicine programs have led the way in creating links among the three paradigms during the past thirty years, in many instances swimming against the reductionist tide of the medical faculty's majority opinion to focus on a more integrative approach to care.

The table on page 60 outlines the disciplines that inform the three paradigms and the techniques and strategies that flow from each of them. Obviously, there is too much here for any formal medical or other health professional educational program to cover. In addition, the role modeling among medical public-health faculty tends to focus exclusively on one of the three paradigms. Students will therefore need to possess an independence of purpose and stubbornness of spirit to pursue their own broad education as they work to achieve the credentials of a scientifically based healer. The medical student of today should understand, work with, and, as I believe possible, synthesize all three paradigms. Alternatively, physicians who are already working fundamentally within one paradigm should try to achieve a balance of tolerance and respect for the two other paradigms.

Crossing bridges between paradigms involves more than just knowledge and technique. There is the matter of commitment to human service. There is also the question about the appropriate perpetuation of a special subset of society to take charge of people's health care and be given extraordinary privilege in return for two things: carrying the torch of hope and the tools of therapy for those who become sick, and initiating the policies and programs that enhance and sustain the population's health status and aim to reduce the overall burden of illness and disease upon the nation.

Are these health professionals doing something special after all? If so, what is their social contract? What do they profess and promise to society? This brings us to the question of motivation and covenants, discussed in the final section.

Section IV—The Need for a Tenacious Loyalty

Chapter 9

Why Become a Caregiver?

Now we must consider the complex issue of motivation, to which I have previously alluded only briefly. It is a problem that will, and rightly should, haunt aspiring young professionals until they have made the final decision about their practice area.

The wide variety of motivations for entering the health care profession stem from the personal values and interests held by those entering the field. In the end, the variety makes for creative and useful health care career choices that benefit both the patient individually and the public at large. Indeed, health care would still be back in the Dark Ages if no physicians had chosen to turn from rendering bedside care to becoming pathologists and laboratory directors. A broad, in-depth medical education is necessary for pathologists and clinical laboratory professionals to facilitate information gathering and diagnostic and therapeutic decision making.

Other specialties of medicine are also highly technologic in nature, requiring little personal interaction with the patient. Radiology, both diagnostic and therapeutic, is an example. In many other areas of specialization—

genetic manipulation or laser treatment, for example—necessary scientific skills may quite properly transcend the interpersonal skills required to develop a therapeutic relationship as a potential healer with particular patients. In such instances, the healing is more in the intervention, treatment, or manipulation and less in the relationship between the particular purveyor of the technology and the patient.

For many decades, Guido Majno, a world-renowned pathologist and biomedical scientist, has maintained a scholarly interest in the history of medicine, and his scholarship and writing reflect as much anthropology as history. In a recent essay, he explores in depth the capacities of previous healers, including the fathers of Western scientific medicine, and contrasts their efforts to those of modern physicians:

> When scientific medicine began to perform its healing miracles (only forty or fifty years ago) there was a marvelous opportunity. Ancient medicine had discovered the secret of helping souls. Now it was possible to help bodies as well, thanks to tons of knowledge, chemicals, and machines. It did not quite work out that way. The new generation of scientific healers was carried away by the physical problems, in fact by anything that could be measured. Spiritual concerns are hard to measure. It was assumed that if the body is healed the rest would somehow follow.
>
> Before long the public began to realize that something was missing. We are now in the midst of a rising anti-medical tide, while scores of supposedly "holistic" would-be do-gooders move in to fill the vacuum. At the latest count there are seventy alternative forms of medicine. They certainly have the secret cure—time—and with it they can offer enough hope and smiles to heal 85 percent of all patients.

Marrying High-Tech and People Skills

Majno questions whether we may have gone wrong by suggesting the problems begin in medical school: "The old ways are very difficult to teach; nobody yet has found a way to teach the human approach. [It] has [been] said . . . that the human approach 'cannot be taught—although it can be learned.'" In his conclusion, Majno seeks a remedy.

> The message of history, as I have tried to decipher it, is that scientific therapy has eroded the human care which has always been a key part of the healing process. Young medical students, brought up in the system, may find it difficult or impossible to fight the trend. Maybe so, but there is hope. Awareness of the problem is a first step toward solving it. . . . It may be impossible to stretch minutes into hours, but the quality of those minutes can certainly be improved.

Majno believes that turning to the lessons of past masters of Western medicine and other forms of healing can help physicians learn how to use the diminished time available to them to convey their concern and attentiveness to the patient's suffering. Through the marriage of humanity with the growing supply of scientific interventions, Majno anticipates that today's physicians can reverse the current antimedical trend and become the most powerful healers the world has ever known.

The difficulty with the many kinds of motivation that people bring to the practice of medicine lies in finding a proper balance between a desire to provide direct human service and a need to master a wide variety of sciences and technologies before being recognized as a physician. Without maintaining scientific knowledge and technical competence throughout one's professional lifetime, all the good will in the world can provide only less than optimal care. Alternatively, for those physicians daily involved with the provision of highly personal health services, high technical competence without the people skills necessary to build trust and confidence also leads to far less than the optimal state we seek for our patients.

The Desire to Win

Let us highlight just briefly the differing motivations that bring scientists into their respective fields. I recall being troubled sometimes by the high degree of competitiveness among elite scientists. There is a sometimes pervasive element of seeking, let's say, the Nobel Prize, the brass ring, or the financial gain for discovering some fantastically useful new tool. More common, perhaps, the scientist is driven by the fun of the pursuit and the challenge of the intellectual problem, rather than by a need to serve suffering humanity.

Tracy Thompson, a writer who says her life was dramatically improved by the drug Prozac, has eloquently described her pursuit of the creators of this drug. She wanted to understand why they created it and what they felt after reaching their goal. Bryan Molloy of Lilly Research Labs was the primary scientist of the three inventors of the new drug. Molloy stunned Thompson with his answer to her question, "How does it make you feel to know that what you have done has helped people—to know that this molecule you invented has allowed me to live my life in a way I never thought possible?" Molloy replied:

> This puts me in a somewhat embarrassing position. . . . The company puts itself in the position of saying it is here to help people, and I'm here saying I didn't do it for that. I just wanted to do it for the intellectual high. It looked like scientific fun.

The Desire to Heal

Compare Molloy's motivation with what must have been at the root of the efforts of Edward L. Trudeau, a physician and clinical investigator who became best known for his leadership in establishing the premier American sanitarium for tuberculosis patients (in the Adirondack mountains of New York). Trudeau contracted tuberculosis in 1873, when it was believed that the

disease was uniformly fatal and either inherited or due to some perverted humor or spiritual problem. It was not thought to be infectious.

In 1887, Trudeau undertook a starkly simple and elegant experiment; the results convinced him of the need for fresh air, good nutrition, and ample rest when treating tuberculosis. The experiment involved fifteen rabbits, divided equally into three treatment groups. The rabbits in the first group were injected with a standard inoculum of tubercle bacilli; they were then placed on an island (with no other rabbits) on which they could forage comfortably. One of these rabbits died of the disease; the other four returned to normal life after fibrosis of the initial lesion. The rabbits in the second group were also injected with tubercle bacilli, but were kept in a cage in a dark cellar with minimal nutrition. All five died of tuberculosis. The control group, which did not get injected with tubercle bacilli, was placed in the cellar with the same poor food as the second group. No animals from the control group died, although all lost weight on the regimen.

Trudeau's science, at least in the case of this experiment, arose out of an interest to seek a cure for a generally fatal disease with which he was also afflicted. His motivation was in a different category than the quest for honor, fortune, or intellectual achievement.

The Desire to Serve

An old aphorism, which I find overly simplistic, holds that there are two kinds of people in the world: those who use people and those who serve people. My discomfort with the aphorism is abated, however, if I add a third category to which I find that most other people (including me) belong: those who sometimes use people and sometimes serve people.

Within this third category is a distinction between those people who wish they served others more or all of the time, and those who really prefer to use others more often and more effectively than they currently do. Where do you stand with relation to these categories?

I have always felt that for serious caregivers, the concept of service must achieve a status akin to a secular sacrament that transcends the benevolent self-interest of the businessperson to please the customer in all matters. Service is surely good "business" for the caregiver, but it is also something more fundamental than customer relations efforts for both the caregiver and the care recipient. A customer's need for satisfaction from an automobile dealer, for instance, pales in comparison to the needs and satisfaction of a customer—the patient— in a health care setting, in which the patient requires a businessperson—the caregiver—in whom they can completely trust with matters of grave personal importance (if not life and death).

In the mid-twentieth century, the philosopher Gabriel Marcel mourned the debasement of the concept of service in the modern, bureaucratic, egalitarian state. He saw service to other human beings as the most fundamental, if not the highest, human activity. Marcel was troubled that in our increasingly bureaucratic society the typical citizen felt that he or she owed to others only the minimum standard of service as delineated in a contract—that much and no more—and was less often governed by an actual covenant between two people than by the laws or mores of society.

It is instructive to think of his arguments, made many decades ago, in the context of the modern systems of managed care with their heavy institutional, and hence bureaucratic, overlay of values and procedures regarding the provision of service.

In *The Call of Service; A Witness to Idealism*, Robert Coles, a physician, psychiatrist, and social critic, relates several stories about people he has found who have made a unique commitment to service. He makes an important distinction when he describes his understanding of the differing personal foundational positions taken by his mother and his father with relation to service. Coles, himself a service devotee, finds his parents' approaches equally valid and meaningful.

He describes his mother as a deeply religious person with a lifelong commitment to understanding her motivations and to trying to orient herself and her life to providing service to other people; she created an explicit tie between her daily activities, her philosophy of living, and her religion. His father, on the other hand, is described as someone who dedicated himself to serving others later in life and who seldom articulated his reasons for doing so, being both rather pragmatic ("Just do it!") and somewhat circumspect about what he might find if he probed too far into his deepest motives.

Coles describes his encounter in the 1950s with Thomas Merton, the contemplative monk and writer, and attempts to analyze the nature of the healing impact the monk had on him and others. In Coles's view, Merton's power as a healer arose from the fact that Merton had known and continued to know personal suffering. He was able to draw out the most painful problems from others, because they could perceive that he personally shared in and understood their suffering.

Of course, all of us have our burdens; Merton's gift came from being able to transmit both a sense of his own encounters with difficulty and a nonjudgmental acceptance of other people, whatever their difficulties. Through the story of Merton, Coles presents his readers with the strange paradox of a contemplative monk, who had retreated from the world but was continuously sought out in person and through letters by a wide variety of suffering people. Remarkably, he somehow was effective in ministering to many of them. According to Coles,

> Dorothy Day and Daniel Berrigan and Walker Percy and so many others sought Merton out. I especially remember Dorothy Day's remarks about him: "He had known much pain, and he knew how to lift pain from others." She was content to state those two aspects of Merton without connecting the one to the other in

> what people like me call a psychodynamic way. Nevertheless, she knew that an essential and important part of Merton's life was his passionate desire to minister unto others, to hear from them, learn of their tensions and turmoil, and tell them of his, too. Once Dorothy Day said this about Merton as we talked of his voluminous writing: "He cured with words—all the time he did! I know! I can remember those letters, the good medicine they were to me. And I always knew that with Merton it was the doctor healing himself as well as the rest of us who were his patients."

Coles goes on to describe Merton's impact on a stranger:

> Merton . . . venture[d] to Asia, ever anxious to be connected with wisdom and with healing other than the kind he knew. . . . A person present at the conference . . . remarked upon his kindly manner, the gentleness he radiated and its calming effect on her: to the very last that humane touch of grace offered without guile or pretense to others.

The Service Ethic Versus the Power Ethic

It may well be that the most important insight that I received into the meaning of the service gestalt came when I left the world of doctoring for full-time participation in the world of administering. It took the soul-numbing experience of being an activist administrator to make me appreciate that the world of administration cannot be handled with a service mentality alone. One also needs commitment to some vision of a better future.

My wife and I discovered this when some unpopular decisions I had made prompted anonymous death threats to my wife and me and sinister threats of abduction of our young daughters. An almost daily escalation of this sort of activity, designed to force us to give up and leave town, made our lives miserable. Yet, like most people faced with such a prospect, we recognized that little is gained by giving up, and perhaps all is lost if one yields to the pressure to run.

We decided to stay, but nonetheless discovered that the dread and angst did not go away with each new dawn. Instead, each day merely reminded me that we seemed to be locked in a power struggle with intelligent people operating under a different philosophy, resulting in a serious game of cat and mouse. One day as my wife and I drove to work, we developed a strategy that seemed to strengthen and satisfy us; it was a strategy that also returned us to our service foundations. Each morning, as we mused about what dreadful things might happen to us during the ensuing day, we concluded that we should each decide on one person for whom we would do something positive that day, and report the result back to each other on the way home that evening.

We found that our joy in living returned, our capacity to deal with a hostile environment grew by leaps and bounds, our sense of satisfaction and personal meaning was made whole, and our essentially positive and constructive perception of the world and our place in it was reestablished. We discovered the strength to stay the course and overcome our difficulties.

Tension Between the Service Ethic and the Ethos of 'Scientific' Clinical Practice

One of the best articulations of the divergent pulls on the physician of patient care and the science of medicine appears in Sherwin Nuland's *How We Die: Reflections on Life's Final Chapter.* As I discussed in chapter 6, the drive to solve The Riddle brings physicians into direct conflict with the best interests of some of their patients for whom The Riddle may be of no concern. The Riddle, for Nuland and the young doctors growing to professional maturity over the past four decades, relates to the drive to determine what is happening at the molecular level, primarily because such a discovery may lead to a cure. However, a dogged pursuit of the answers to The Riddle may not always be what the patient wants. The patient , for example, may be in the process of dying and may prefer help with an easier death, rather than an overabundance of costly, high-tech hindrances to a peaceful passing. I recommend Dr. Nuland's book to all beginning practitioners because it describes a real-life situation that every experienced physician and other clinician has inevitably encountered, one with which we all must deal: the process of dying.

Meanwhile, it seems useful to share briefly with you the thoughts of Lewis Thomas, America's famous physician-scientist turned literary figure and popular philosopher. In an interview from his deathbed, Thomas, the consummate devotee of the evolution of living species, seemed to say that the human species is intrinsically good at being useful:

> If we paid more attention to this biological attribute, we'd get a satisfaction that cannot be attained from goods or knowledge. If you can contemplate the times when you've been useful, even indispensable, to other people, the review of our lives would begin to have effects on the younger generations. . . . Plain usefulness.

Because medical science will constitute so much of the education of aspiring professionals, and because biomedical scientists may predominate among their early (and perhaps later) role models, students will be exposed to all of the attitudes and values associated with service and usefulness. They may well find it challenging to harmonize the primary motivations of scientists with the primary motivations of a clinician-caregiver.

A Personal, Simplistic View of Service and Physicianhood

My view of the central motivating characteristic of someone in the direct care-giving professions became

clear to me in a recent episode that involved my barber. He is a naturalized citizen who combines great common sense and cynicism about the world with an instinct that tells him he should stay away from doctors and medicine if at all possible. One day, I observed that he was limping and commented on it. He explained that his right foot had just begun to hurt and that he was sure it would go away soon. He didn't want to talk about any medicines.

Two weeks later, when I made my next visit to the shop, my barber was obviously still in considerable distress from his sore foot; he volunteered that he was thinking about giving up active barbering and running his business from his desk. When I asked, he told me he had not seen a doctor, had no intention of doing so, and had taken no medication. He did permit me to examine his foot, however, whereupon I quickly determined that the most likely problem was an acute tendinitis. I suggested that he might get tremendous relief from some readily available medications.

His response made it clear to me that he was unlikely to get the medicine and that the best way for me to achieve compliance from this nonpatient was to walk the two blocks to the pharmacy, pick up the medicine, and deliver it to him personally. He was certainly surprised when I returned to the shop, remedies in hand.

The next morning on my way to work, I stopped by to see how the medication had worked. My barber reported that he was pain-free and again registered surprise that a doctor was going to all this effort at no charge to him. He has been well ever since and has even taken a few precautions to protect against a recurrence. He has been cured completely, or so he believes, and it made me happy to have made some good guesses about how to help him get relief.

As for myself, I was surprised that my sense of satisfaction at a simple and routine intervention in a commonplace disorder was every bit as great as at any of those rare moments in medicine when one deciphers a complex problem and solves a therapeutic riddle. From the patient's perspective, a nettlesome problem had been solved. It did not matter how simple or demanding the intellectual or technical intervention required of the physician to achieve the solution. I was in fact, by nature, a physician.

I conclude that caregiving health professionals are likely to be happiest in their profession if, in fact, helping others gives them real satisfaction. Do you like to hold doors open for others to pass through, or do you prefer to have others hold doors for you? Would you like to develop a healing presence or personality as described in Coles's essay on Merton? Or would you rather prescribe a pill and move on to the next case?

Although these questions are simplistic, and although the most tangible indices of service orientation are different for each person, they point to the importance of bringing honesty and careful self-reflection to selecting a career at which you can work both effectively and happily.

A New Service Ethic: Collaboration

People just entering the profession of medicine face a new challenge, or an old challenge with a new and expanding dimension. By this I refer to the growing number of professionals on the health care delivery team and the increasing complexity of the health care delivery system. It is no longer simply patient and doctor; today, it is the patient and literally hundreds of members of the health care team. Teamwork is being brought to bear on the problems of individual patients within the context of the entire population's needs and health status. One physician's dedication to serve a patient is no longer sufficient to achieve the desired outcome. Instead, we must learn to collaborate across professions in the patient's best interests.

This collaboration must occur at the bedside and consultation room levels, as well as at the juncture where institutional and organizational ethics and values come together. This imperative, taking on a heightened importance, is not new because we have always had to work in teams. The current environment, however, makes collaboration critical to success; those who cannot collaborate will not be as successful in the final analysis.

For good and for bad, the impact of institutional values on individual values and behaviors, along with the interplay between individual and organizational ethics, will become increasingly important to health care delivery. Service-oriented and service-driven professionals will want to be continuously involved in shaping both the interplay of professionals on the team and the organized systems within which the team works. There are techniques available to enhance collaboration, and satisfactions arise from successful collaboration. I hold that the commitment to help and the drive to excellence in professional service must now also include the drive to collaborate successfully with others who can enhance clinical outcomes. Thus, to those tenets of competence and caring that have guided physician practice since Hippocrates, we must now add *collaboration.*

Chapter 10

Commitment and Healing

Excerpts from the Physician's Oath by Hippocrates

> I will look upon him who shall have taught me this art even as one of my parents. I will share my substance with him, and I will supply his necessities, if he be in need. I will regard his offspring even as my own brethren and I will teach them this art, if they would learn it without fee or covenant. I will impart this art by precept, by lecture and by every mode of teaching, not only to my own sons but to sons of him who has taught me, and to disciples bound by covenant and oath, according to the law of medicine.

> The regimen I adopt shall be for the benefit of my patients according to my ability and judgment, and not for their hurt or for any wrong. I will give no deadly drug to any, though it be asked of me, nor will I counsel such, and especially I will not aid a woman to procure abortion. Whatsoever house I enter, there will I go for the benefit of the sick, refraining from all wrongdoing or corruption, and especially from any act of seduction of male or female, of bond or free. Whatsoever things I see or hear concerning the life of men, in my attendance on the sick or even apart therefrom, which ought not to be noised abroad, I will keep silence thereon, counting such things to be as sacred secrets.

So reads the portion of the Physician's Oath that generations of medical students have taken upon graduation from medical school. This distillation of the teachings of the "father of medicine" has endured for a remarkable period of time; it was recorded around 400 B.C.! In fact, the beginning of the oath calls on Apollo Physician, Asclepius, Health, Panacea, and all of the gods and goddesses to serve as witness to the words that follow within the oath. Although historians largely agree that the oath was written not by Hippocrates but by his followers after his death, the oath is consistent with the distinctive combination of humanistic concern and practical wisdom that appears in the writing of Hippocrates, an emphasis that has inspired and guided many a physician.

Precepts to Cherish or Question

Thus, although Hippocrates probably did not construct the Physician's Oath, it affords some insight into the "person" Hippocrates. To me, the meaning of the Hippocratic oath and the reason for its enduring value is its highly personal quality, reflecting the basic concept of devotion to people and a desire to serve them.

Upon careful study, the oath offers much wisdom, even for modern-day physicians. It is also clear, however, that it contains some statements that do not reflect the beliefs held by many twentieth-century physicians. Scholars have noted that, in light of current knowledge and the needs of this century, the oath could be improved with reinterpretation. It no longer seems to capture all the responsibilities and obligations of physicians.

Medicine has become enormously complex; consequently, today's modern physicians not only practice general patient care, but serve as highly trained specialists, research scientists, full-time teachers, or administrators concerned with medical education, delivering health care services, or organizing our vast biomedical research efforts. Comments physician and ethicist Edmund Pellegrino:

> In a simpler world, that [Hippocratic] ethic long sufficed to guide the physician in his service to patient and community. Today, the intersection of medicine with contemporary science, technology, social organization, and changed human values have revealed significant missing dimensions in the ancient ethic.

Medical Training—Who and How

Among the aspects of the Physician's Oath that many say are outdated are its tenants about medical training and eligibility to join the profession. The oath holds that doctors should teach medicine to their sons, to the sons of their teachers, and to other disciples choosing to live by the "law of medicine." Of course, as more and more women join the health care field, the male bias of the Physician's Oath is no longer appropriate. And, given the intricacy of modern medicine, teaching by apprenticeship or discipleship is no longer feasible. As physician John Leversee notes, health science educators and planners have greatly broadened the kinds of training they look for in candidates for medical school and in the field.

Delivering Care—Who and How

The need to expand the number and kinds of persons involved in delivering health care today is clear. Not only have the numbers of health care professionals increased, but new kinds of professionals—such as occupational therapists, respiratory therapists, nurse practitioners, and radiologic technicians—have taken on unique roles. Technological developments and changing health care needs have made it necessary to train nonphysician professionals in broader skills and responsibilities. No longer is it a particular advantage to be a son of a doctor or a teacher of medicine. Motivation and performance are more important than legacy for gaining entry to education in the health professions.

New Ethical Considerations

Several other circumstances have drawn modern medicine away from its Hippocratic traditions. There is a need to expand our understanding of the ethics of medicine. Biomedical research involving human subjects, for example, challenges the idea that physicians may use only their skills to benefit those in their care. The notion of the physician as a benevolent and paternalistic figure who makes all the decisions for the patient is inconsistent with today's notion of the educated health care consumer. Informed consent was not an issue in Hippocrates' time. Changes in public and medical attitudes about abortion and euthanasia could also make it difficult for today's physician to honor the portions of the oath that proscribe these procedures.

New Social Responsibilities

Still others have argued that the most important reason to update the Physician's Oath is its lack of attention to the responsibilities of the medical profession as a whole. The tension between the interests of the individual and those of the community is not acknowledged in

the oath, which focuses exclusively on the responsibilities of physicians to individual patients. Pellegrino comments on the significance of the notion of communal responsibility:

> Society supports the doctor in the expectation that he will direct himself to socially relevant health problems, not just those he finds interesting or remunerative. The commitment to social egalitarianism demands a greater sensitivity to social ethics than is to be found in traditional codes.

William F. May agrees with Pellegrino. In *The Physician's Covenant: Images of the Healer in Medical Ethics*, May describes several images that capture the ways in which society perceives the physician (and in which physicians may perceive themselves). One image is what May calls the "covenanter." As covenanter, the physician owes a debt to society for his or her education; he or she also owes a debt to patients, who provide a kind of education for the doctor who "practices" on them. In return for public support and public trust, the physician as covenanter reciprocates with service, fidelity, accountability, and responsibility for distribution of basic services. Each of May's images of the healer provides a fascinating window on the roles and responsibilities of the healer. I heartily recommend his book to all of those, whether just entering or well-established, in the healing professions.

Pellegrino agrees with May that physicians have a covenantal relationship with society and cannot absolve themselves from responsibility for deficiencies in distribution, quality, and accessibility of care to the poor and disenfranchised. These defects, widespread today, are examples of the kinds of situations that the Physician's Oath, even with its ethical sensibilities and high moral tone, is insufficient to address.

The Durability of the Ancient Oath

How, despite its jagged-edged fit with modern medicine, does the Physician's Oath endure? Although several attempts have been made to create new oaths that convey the current context for medicine, most graduating medical students still prefer to take the ancient oath. Perhaps it is because they can thereby make a spiritual link with the fascinating, almost magical, world of ancient Greece. Or perhaps reciting the oath connects them in some way to the 2,500-year-old roots of Western scientific medicine, to the prestige of a select group, or to history. In brief, the oath allows the new physician to become part of a tradition that transcends personal interests and rivets attention on superordinate goals.

Certainly, the oath has persisted because of its core premises: competence, commitment, and caring, those foundational values that remain at the heart of modern physicianhood. A few years ago, however, I made my own attempt to fashion a revised version of the Hippocratic oath; it harkens back to some of the enduring and fundamental qualities of the original while integrating some of the realities of modern life. I firmly believe that, today more than ever, a modern

William F. May's Images of the Healer

Fighter The healer is a fighter against death, battling such enemies as cancer and heart attacks. Patients prize a kind of military intelligence, tactical brilliance, self-confidence, and stamina in the healer. The language of war dominates the understanding of disease (e.g., cancer "invades," the heart suffers an "attack") and shapes the healer's response (e.g., searching for a magic "bullet," utilizing an "armamentarium" of drugs).

Parent The healer's role is to nurture and reassure patients and shelter them from the powers that are harming them. Kindness rather than candor is the chief moral virtue expected of the healer. As between parent and child, the healer's relationship with the patient is characterized by compassion (e.g., shared suffering) and self-expenditure (i.e., the imbalance of knowledge and power define the healer as the giver and the patient as the receiver).

Technician Excellent technical performance becomes the effective center of the professional ethic; the healer finds satisfaction in service, but technology and technical performance supply his or her ultimate justification. The healer's white lab coat points to the scientific origin of medical authority and hints at the body mechanic at work. The criteria for admission to medical school and the grading system that prevails there emphasize the preeminent place of technical performance in the formation and career of the professional.

Covenanter Healers have distinctive obligations to their patients and to their teachers (as in the Hippocratic oath). Patients effectively "teach" healers by allowing healers to "practice" on them. Healers also owe a debt to the society that supports their training; they owe competence, accountability, the courage to hold fellow professionals accountable, and responsibility for the distribution of basic services. Service and fidelity are chief moral virtues of the healer. The patient is a bonded partner in pursuit of health.

Teacher The healer respects patients' intelligence and power of self-determination. To be an effective teacher requires a kind-of imagination that permits the healer to enter into the life circumstances of the patient/learner to reckon with the difficulties the patient faces in acquiring, assimilating, and acting on what he or she needs to know. These skills are particularly important in preventive, rehabilitative, chronic, and terminal care; they often go unrewarded in third party payment systems and receive little attention in medical schools and residency programs.

Hippocrates and the Hippocratic profession need a compelling and meaningful covenant to guide activities that otherwise promise to become even more complex, bureaucratic, and impersonal.

The Oath of the Modern Hippocrates

> By all that I hold highest, I promise my patients competence, integrity, candor, personal commitment to their best interests, compassion, and absolute discretion and confidentiality within the law.
>
> I shall do by my patients as I would be done by; shall obtain consultation whenever I or they desire, shall include them to the extent they wish in all important decisions, and shall minimize suffering whenever a cure cannot be obtained, understanding that a dignified death is an important goal in everyone's life.
>
> I shall try to establish a friendly relationship with my patients and shall accept each one in a nonjudgmental manner, appreciating the validity and worth of different value systems and according to each person a full measure of human dignity.
>
> I shall charge only for my professional services and shall not profit financially in any other way as a result of the advice and care I render my patients.
>
> I shall not accept financial or other incentives as a reward for restricting patient access to medically needed diagnosis or treatment.
>
> I shall provide advice and encouragement for my clients in their efforts to sustain their own health.
>
> I shall work with my profession to improve the quality of medical care and to improve the public health, but I shall not let any lesser public or professional consideration interfere with my primary commitment to provide the best and most appropriate care available to each of my patients.
>
> To the extent that I live by these precepts, I shall be a worthy physician.

Covenant for Collaboration

In the relatively short time since I drafted the above oath, there has arisen even greater recognition of the value (and in many cases, the necessity) of health care professionals delivering care in teams. The personal commitment of the physician to the patient was sufficient when the medical team averaged one doctor and three other professionals. However, the health care team has expanded to include over 120 distinct health professionals. (Not counted are the variety of other people who have a role in health care decision making, including health system administrators, third-party payers, and patients and their families.) Collaboration has taken on an importance of which Hippocrates never dreamt.

Thus, no modern covenant for health care professionals would be complete without acknowledging the need for collaboration among the members of the health care team. In the complicated and sometimes perplexing arena of health care, only groups of professionals who function as a caring and competent team can deliver high quality, highly effective care. In acknowledgment of the importance of collaboration, some colleagues and I have developed a health professions covenant for our times that could supplement the individual oaths taken by graduates of each of the health professions.

A Health Professions Covenant for Our Time

> As a health care professional dedicated to enhancing the health care needs and well-being of individuals and communities, I pledge collaboration with all of my health professional colleagues similarly committed, and promise to place the patient's and the public's interests above the self-interests of my individual profession.

Fulfillment of the more traditional tenets of health care espoused by the ancient Hippocratic oath—competence, commitment, and caring—increasingly depends on collaboration. It is my hope that health professionals consider incorporating such a statement into the covenantal ceremonies preceding their entry into the world of practice.

Institutional Values and Commitment

Most people spend the majority of their waking hours within larger institutions—at work or at school, for example. Our society is only now beginning to appreciate how an institution's values can have far-reaching effects. For example, an institution that declares its mission to be improving the health of the community undermines its credibility and commitment when it does not take tangible steps to improve the health of its own employees (for example, through anti–cigarette smoking and anti–substance abuse campaigns, or through diet and exercise programs), who are expected to carry out its mission.

Health care institutions that place excessive value on the number of patient visits their professionals accumulate, the number of dollars saved or dollars earned, and other economic goals run the risk of compromising care by placing too many constraints on the professionals. When rationing technology and, perhaps more significantly, time characterize an institution's mores, commitment to serving patients and collaboration in meeting patient needs are jeopardized.

A revealing perspective on institutional values about the use of time emerges from a 1973 study of senior divinity students at Princeton University. The authors, psychologists John Darley and C. Daniel Batson, contrived an elaborate experiment to study people's capacity to help someone in need. (It would not be permitted today because it involved deceiving the subjects.)

Near the end of the semester, the divinity students were to meet individually with an instructor on a topic. A portion of the students was instructed to talk about the

parable of the Good Samaritan; the other students were asked to discuss suitable jobs or professions for seminary students. Students were given a few minutes to prepare, after which time the staff assistant returned with instructions for going to an adjacent building to deliver the talk to the instructor. The students were informed of one of three time constraints:

"Hurry, you're already late." (the "hurried" group)

"They're ready for you now—please go right over." (the "somewhat hurried" group)

"It will be a few minutes before they're ready for you, but you'd best head over." (the "unhurried" group)

On the way to the adjacent building to present the talk, each student encountered a young man writhing on the ground in pain. He was actually a paid, trained observer playing the modern counterpart of the sufferer encountered by the Good Samaritan. His job was to record which students stopped, what they did when they stopped, and how long they stayed.

When the data were analyzed, the only variable that correlated with whether a student stopped to offer assistance was the time available before the student was expected to arrive. Of the group as a whole, 40 percent offered some form of aid to the man in pain. When evaluated against time constraints, 63 percent in the "unhurried" group, 45 percent in the "somewhat hurried" group, and only 10 percent in the "hurried" group stopped to help. There was no escaping the conclusion, wrote the authors, that the decision to care for a person in distress was predominantly a function of having the time to do so. Put another way, even those with the very best intentions require time to be of help to a suffering person.

This tragic choice between time and caring occurs every day in our nation's hospitals, health clinics, and doctors' offices. What we know about the placebo effect, taking care of those who are suffering, staying by those who are facing death, and the healing power of words tells us that rationing time could have dire consequences, at least, for patients. As we work to make the health care system more cost-effective, we recognize that reducing the time spent with a patient and, along with it, the tools of communication, companionship, compassion, and shared decision making may indeed reduce costs. But it will also dramatically compromise value, and may prove disastrous to the whole of medicine. It will undermine the healing relationship between health care professionals and patients, as well as between institutions and patients.

As we move toward utilizing large and complex not-for-profit organized delivery systems based upon prepaid, capitated financial arrangements, the traditional covenantal understanding between patient and physician could be dramatically affected. If the dual objectives of patient autonomy and empowerment and physician advocacy for the patient's best interests are to be sustained within these organized delivery systems, then it is clear that these systems and corporate entities will have to agree to an institutional ethic that supports these ethical priorities for patients and physicians. Law professor and ethicist Susan Wolf has presented a recent detailed review that demonstrates the criticality of the issue of institutional ethics and their developing impact on physician ethics.

How might institutions, ranging from small clinics and community hospitals to massive academic health centers, approach the concept of institutional ethics? Health policy expert David Mechanic notes that, to counter the erosion of public trust in various elements of our health care system, medical institutions are conducting public information programs, seeking feedback from patient-consumers, and educating their staffs to become more responsive and culturally sensitive. Mechanic also comments on the initiatives designed to empower patients further:

> These range across preventive health programs, family planning, pregnancy and childbirth, women's health, and chronic disease programs. At the social level, health institutions are more likely to put patient representatives on their boards and committees. In some long-term patient services, the patients themselves or family members may participate in certain recruiting or hiring decisions. Moreover, it is not uncommon for client groups themselves to organize and administer services, as exemplified in some programs for persons with disabilities.

Some institutions have developed formal institutional covenants. For example, with the help of an ethicist, M.D. Anderson Cancer Center in Houston has created a patient-based code of care. Edmund Pellegrino emphasizes that people not involved in health care professions must be included among the drafters of institutional covenants. Other institutions could, and perhaps should, follow suit.

Two sayings derived from religious writings, when transformed into the health care vernacular, may serve to summarize some of the key personal and institutional values that I advocate here. The first is St. Paul's: "There are faith, hope and charity! These three! And the greatest of these is charity!" The health care version might be as follows: "There are prevention, curing, and caring! These three! And the greatest of these is caring!"

The second saying is: "God is first; everyone else is second; and I am third!" This epigram could become: "The patients (and the public) are first; the profession is second; and I am third!"

It is crucial for the next generation of physicians and other caregivers to continually reexamine the validity and cultural and personal meaning of an oath or covenant. The alternative is contractual health care that carefully delineates what and how much will be done in exchange for what and how much—and no more! If, in fact, there is any validity to the central theme of this book—that our health care enterprise exists to provide competent and caring intervention to suffering people—then it clearly follows that clinicians covenanted to that role are best suited to provide patients with satisfaction in their quest for mercy.

Postscript

When she read the penultimate form of this manuscript, a friend and experienced clinician-educator commented that she was left with one unanswered question, a question that she confronts with increasing frequency in her interactions with medical students and generalist physicians in postgraduate training. She indicated that she deemed my manuscript incomplete without at least attempting to address this question. Many members of the young, up-and-coming generation of clinicians, she explained, are asking, "If we are to internalize this commitment to service, to focus primarily on the sufferings of others, and to adhere to the primary ethical precept of competence based upon the latest science and the latest technology with a large dose of psychology and sociology thrown in, how can we be fair to our spouses and children and do our share as friends, neighbors, and members of the community?" They wonder, "Aren't we allowed some time for our recreation and personal development? In brief, how can we have—or get—a life?"

At first, I believed that I couldn't even attempt a response, partly because I am at the other end of the professional and personal trails and perhaps can't adequately place myself in their shoes. Mostly, however, I hesitated to respond because I am a biased observer whose views should be somewhat suspect for the young. After all, I currently am not a practicing clinician. More important, I grew up in what I think of as the Vince Lombardi era of medicine, an era in which admission to medical school presumed that one had the physical and mental strength and durability sufficient to endure the most rigorous training—training to prepare for the most serious of situations. The atmosphere that prevailed can be likened to both the benefits and the drawbacks of the well-known Green Bay Packers championship football teams coached by the legendary Vince Lombardi. In football, this male-dominated, driven environment produced spectacular victories, but at what personal sacrifice? In medicine, the Lombardi era was one in which very few students were married during medical school (because they might lose their single-minded focus); in which only five to seven percent of incoming medical school classes were women; in which many of the best residency programs in surgery, medicine, and some other specialties involved living in the hospital (with explicit and implicit encouragement not to marry); and in which the standard operating routine during the three to five years of postgraduate hospital-based training was to be on duty in the hospital every other night and every other weekend. Having survived and benefited from that educational environment, I have been shaped by it as well, I felt that I should remain removed from any effort to translate the values of the clinical professions to the current age for the upcoming generation of healers.

My friend still wasn't satisfied, however, after hearing my defense. Upon reflection, my reticence to address the question, though well founded, now strikes me as something of a cop-out; I know from personal experience that her students' question is one that I hear frequently. Although I am aware that my answer may be unsatisfying to some, here it is.

First, if becoming a committed and competent scientific healer is your professional goal, you must challenge yourself to accomplish that in conjunction with your other goals as a person with family and civic responsibilities. You have a constellation of personal and professional objectives, which may be one of your major generational contributions to the health professions. Second, you must realize that it is virtually impossible to accomplish this alone, as a professional single-handedly in charge of the delivery of health care services to a panel of patients or to a population; you must work with others in a team or group with the same general values and aims. With these realities in mind, we are in the midst of a huge transition to implement various forms of health care service. There is no escaping that many of these forms are grossly inadequate, sometimes fatally flawed, and occasionally marred by human venality accompanying altered financial incentives to get rich in the business.

There may always be the Vince Lombardis in our professions who can productively give 110% of themselves to the care of the sick. We should celebrate them. We must celebrate equally the new road that the rest of us must find to achieve a balance between personal and professional goals. Women physicians are leading us toward that balance, because they, in particular, are insisting on being fair to their children and their families. As we all know, that insistence should be shared by men physicians, who (married or not) need to realize that they, too, must be able to participate fully in the lives of their families and their communities.

In sharp contrast to my current way of thinking, in my early professional days I honestly believed that I was so committed and involved with care of the sick that I owed absolutely nothing to any other aspect of society. In addition, I was so underpaid and so lacking in funds that I deemed myself clearly excused from making any financial contribution to any community efforts, whether it be my college, church, or the United Way. I must admit that that frame of mind persisted well beyond the time when I was so busy and so financially challenged. The fact that people like me are still in leadership roles in may of our institutions, programs, and organizations thus proves to be a major difficulty for young clinicians today.

The world of practice is evolving, however. We are, in the truest sense, all in this together. The older generation must adjust as rapidly and effectively as it can, without losing sight of the core values of the enterprise (which are what I have tried to address in this book). More importantly, the younger generation must lead us in the changes for the next millennium, trying (I hope) to sort out and preserve the core values of the past.

It seems to me that all health professionals, and physicians in particular (as the "high priests" of scientific medicine), should reflect on the danger of being perceived as being too removed from the interests of the average citizen—as being too elitist and therefore open

to the charge of arrogance. Our professional culture often bases its drive to excel on such a committed single-mindedness that family lives are compromised, spouses are ignored, and children grow up not knowing their parent. As a result a message of contradiction, paradox, and falsehood is sent to a watching public. The message says that this elite profession, to whose members society transfers much wealth and accords much status because of their commitment to alleviating human suffering, actually in its professional workings runs over people and sometimes destroys lives. Health professionals must be certain that human values are expressed in our profession and in our interactions with the people we serve. Thus, we need to reshape our professional lives to allow our clinicians the flexibility to have healthy families and participate more fully in the community at large. If we do not do so, we will hurt the health professions in the long run.

We look forward to these new adjustments, but it is true that younger professionals need help now, tomorrow, or next week; therefore, there must be people to whom to turn for advice regarding this interface between professional and personal development. Clearly, for clinicians, these persons should include our professional mentors—people to whom, all too often, mentees are overly reticent to turn. It is true that such an approach could be poorly handled or disregarded by an inadequate mentor; but you may be surprised at the constructive and thoughtful responses that such queries elicit.

Upon reflection, I realize that I have had many mentors who, in the aggregate, have helped me profoundly. One of my experiences is particularly relevant to discuss here. As I was completing my last year of medical training, I was offered three job opportunities in three parts of the country, each with different basic characteristics and different prospects for my wife's professional future as a basic medical scientist. I laid all of this out in great detail in a multipaged epistle to one of my clinical mentors (who, at the time, was 3,000 miles away) and asked him for advice on making the choice. He was a medical leader with an accomplished wife and a full and well-developed family life.

I got back a characteristically terse and incisive one sentence answer, which went something like this: "Dear Roger, In my experience, decisions like this are periumbilical rather than supratentorial. Good luck. Sincerely."

That advice, delivered in such a simple and direct way, had a great impact on me and on us as a couple. It somehow empowered us to think about what was best for our collective future; it helped me to put rational analysis in it proper place. My mentor's reference to gut feeling, to intuition, was shorthand for placing one's professional life in the perspective of the more holistic concerns of family, environment, and background.

If our professional worlds have become bigger and seem more impersonal than they once might have been, we need not hesitate to seek advice and assistance from others more experienced regarding some of the important personal challenges we face.

One of the next generation's major contributions will be to establish the criticality of a balanced life even as its members achieve heightened capacities to treat disease, heal people, and promote health. As you, in this rising group, attempt to balance your legitimate goals and the mores of the past in a shifting health care environment, you will likely have a difficult time working it all out. But only you can do it. Even we—in the sunsetting generation—know that, and we are counting on you to get it done.

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